CHAPTER I: GENERAL INFORMATION

SCOPE

All area programs/LMEs, contract agencies of area programs/LMEs, CAP-MR/DD providers, and direct enrolled residential providers shall follow the documentation requirements contained in this manual. This manual meets Medicaid regulations and has been approved by the Division of Medical Assistance.

REQUIRED ELEMENTS

All providers of MH/DD/SA services in North Carolina as identified in the Scope may develop forms which reflect the require elements as specified in this manual or chose to utilize DMH/DD/SAS sample forms. (See Appendix D)

Note: For CAP-MR/DD consumers, the person-centered plan of care and cost summary located in the 2005 CAP-MR/DD manual shall continue to be used.

CONSUMER RECORDS TYPES

A consumer record is required to demonstrate evidence of a documented account of all service provisions to a consumer including pertinent facts, findings, and observations about a consumer's course of treatment/habilitation and treatment/habilitation history. The consumer's record chronologically documents the care of the consumer and is an essential element in contributing to a high standard of care.

A consumer record may be paper-based or computer-based. A computer-based record is defined as an electronic consumer record that resides in a system specifically designed to support users by providing accessibility to complete and accurate data, alerts, reminders, clinical support systems, links to medical knowledge, and other aids. A record is not considered computer-based if it is only electronically stored in a computer as a word processing file and not as a part of an electronic database system.

If electronic signatures are used, the requirements specified in Chapter VIII- General Consumer Records Requirements shall be met.

REVISED REPORTING REQUIREMENTS

The following LOE reporting requirements have been eliminated or revised:

1. The Disability Detail Record is no longer required. The record types label in the Client Data Warehouse (CDW) technical reporting requirements as record types (14, 34, and 84) are record types affected by this change. If these record types continue to be reported, the current processing rules shall remain in effect (The Division may require the submission of CAFAS scores on a random sample of consumer's on an annual basis.)
2. In the Demographics Record, the Commitment Status and the Court Order Type is an optional field. The record types labeled 11,31 and 81 in the CDW technical reporting requirements are the record types affected by this change. If these record types continue to be reported, the current validation processing for the range of values specified in the CDW Data Dictionary shall remain in effect.

Note: The latest version of the Technical Specifications document (November 2002, Version 1.5), is posted on the Division's web site (www.dhhs.state.nc.us/mhddsas). A copy may also be obtained by contacting the Communications and Training Section at (919) 733-7011.

CHAPTER II: PROVIDER QUALIFICATIONS

In order to provide services to persons with mental health, developmental disability or substance abuse issues, the provider shall demonstrate knowledge, skills and abilities required to serve the consumer based on the individualized service plan as evidenced by the provider agency's policy. Each MH /DD/SA service definition identifies the specific qualifications required for delivery of that service.

Note: See Appendix A for provider qualifications.

Note: For CAP-MR/DD providers, provider qualifications as specified in the 2005 CAP-MR/DD Manual shall contiunue to be used.

CHAPTER III: MEDICAL NECESSITY/AUTHORIZATION

MEDICAL NECESSITY

Delivery of all services shall be based upon a finding of medical necessity and/or an assessment of the consumer's need(s) by a qualified professional. Documentation in the consumer's record shall establish the finding of medical necessity.

Policies and procedures shall be developed for the purpose of establishing medical necessity utilizing at least one of the following methods:

- for substance abuse services, ASAM-*PPC*-2R(American Society of Addiction Medicine-*Patient Placement Criteria*);
- for CAP MR/DD, MR2 and NC SNAP;
- for developmental disabilities; North Carolina Support Needs Assessment Profile (NC-SNAP);
- children in the NC Infant-Toddler Program, Procedures documented in the North Carolina Infant Toddler Program Manual (Bulletins 16 and 22); and
- medical necessity as established in the DMH/DD/SA Service Definitions

SERVICE ORDERS

All MH/DD/SA services reimbursed with Medicaid monies shall be ordered prior to or on the day the service is provided by the appropriate professional as defined in the Medicaid manual and DMH/DD/SA Service Definitions. All area programs/ LME's and provider agencies shall have standing orders for screenings, evaluations, and case consultations.

Each area program/LME shall have a policy regarding how the order of services shall be documented. For example, the area program/LME may develop a policy which requires all services to be documented on a service order form and signed by the appropriate staff on or prior to the date of service, or the policy may require the appropriate staff sign the service plan which identifies the service to be provided and is signed prior to or on the date the service is provided.

For outpatient specialized therapies, (i.e. occupational therapy, physical therapy, speech therapy, and audiological services) a verbal or a written order by a physician shall be obtained for services prior to the start of the services. The verbal order shall be documented in the record and include the date the order was given, who gave the order, who received the order, and what services were ordered. The verbal order must be countersigned within 30 calendar days of the date of the verbal order. Service orders for outpatient specialized therapies cannot exceed a six-month period that begins on the date of the verbal order or the date the physician signs the written order, whichever occurs first. Service providers must review and renew or revise plans and goals at a minimum of every six months, including obtaining another dated physician signature for the renewed or revised orders.
(For additional information, see the North Carolina Medicaid Special Bulletin Section or Medical Policy No. 8F. The bulletin and Medical Policy Section may be obtained from the Division of Medical Assistance web site at www.dhhs.state.nc.us/dma or by contacting EDS at 919-851-8888.)

Note: All CAP- MR/DD services shall be ordered at least annually.

AUTHORIZATION

Once the limits for unmanaged outpatient visits has been reached, services paid by Medicaid and/or State monies, prior approval shall be obtained from the area program/LME or the external utilization review entity for authorization to continue the service. Private insurance may have specific requirements for establishing medical necessity and obtaining authorization. When this occurs, the private insurance requirements shall be followed. When an individual has both Medicaid and Medicare, Medicare prior approval/authorization requirements supersede Medicaid requirements except in those cases where the recipient is provided a service that is not covered by Medicare. In that case, Medicaid prior approval/authorization requirements shall be followed along with the required F2 stamp for reimbursement.

The area program/LME is responsible for conducting the initial authorization for child residential services. For residential services-Level I, the area program/LME is responsible for all authorization of services. For Level II (both Family and Program type) and Level III, the area program/LME authorizes the initial 120 days. After the initial 120 days, ValueOptions is responsible for authorizing continued stay. For Level IV child residential services, the area program/LME conducts the initial authorization for 30 days, after which time ValueOptions is responsible for authorizing continued stay.
Note: ValueOptions only authorizes services for child residential services with four or more beds. If there are less than four beds, the area program/LME is responsible for authorizing services.

Authorizations for Psychiatric Residential Treatment Facilities (PRTF) services, discharges from a PRTF to a residential facility, when a child is hospitalized directly from a residential facility and returns to the residential facility, and outpatient treatment services for which Medicaid will reimburse shall be authorized by ValueOptions.

For children enrolled in the North Carolina Infant-Toddler Program, services listed on the Individualized Family Services Plan (IFSP) and the signature of the individual representing the appropriate Infant-Toddler Program coordinative agency (ies) for the service(s), or designee is the authorization for services listed on the IFSP.

For outpatient specialized therapy services, i.e. occupational therapy, physical therapy, speech therapy, and audiological services, up to six unmanaged visits per discipline, per provider type are allowed without prior approval. After six unmanaged visits, prior approval is required from Medical Review of North Carolina (MRNC) for continued treatment. For additional information, see the North Carolina Medicaid Special Bulletin Section or Medical Policy No. 8F. The bulletin and Medical Policy Section may be obtained from the Division of Medical Assistance's web site at www.dhhs.state.nc.us/dma or by contacting EDS at (919) 851-8888.

For services that do not require authorization by an external reviewer as noted above but per service definition requires authorization/utilization management, the LME/area program shall develop a policy which establishes an internal process for the authorization/utilization management of these services

CHAPTER V: SERVICE PLANS

INDIVIDUALIZED SERVICE PLAN

The individualized service plan shall begin at admission and shall be updated/revised to reflect additional needs or changes in the consumer's condition.

CONTENTS OF INDIVIDUALIZED SERVICE PLAN

The individualized service plan shall be based upon the consumer's assessed need(s)/problem(s), with recognition of the consumer's and family's capabilities, interests, preferences, aspirations, and treatment and personal support needs.

An individualized service plan is a comprehensive plan that includes:

1. service goal(s);
2. specific service modalities/interventions with frequency and duration;
3. responsibilities of each member of the treatment/habilitation team;
4. a target date that reflects the timeframe within which the goal(s); modalities/interventions and frequency/duration and responsibilities of each member of the treatment/habilitation team will be reviewed. A target date shall not exceed 12 months.
5. signature of staff and consumer/legally responsible person

Note: Requirements on how to review and revise the service plan are located in the Review/Revision of the Service Plan section in this chapter.

Note: For CAP-MR/DD consumers, the person-centered plan of care and cost summary located in the 2005 CAP-MR/DD manual shall be used.

The service plan shall include both the staff and consumer/legally responsible person's signature demonstrating the involvement of all parties in the development of the plan and the consumer/legally responsible person's consent/agreement to the plan. If the entity that developed the service plan is unable to obtain the signature of both the staff completing the service plan and the consumer/legally responsible person, there shall be documentation on the signature page or in a service note reflecting the attempts to obtain the signature and documentation stating why the signature could not be obtained. When this occurs, there shall be ongoing attempts to obtain the signature(s) as soon as possible.

When the phrase "consumer/legally responsible person" is used and the consumer is a minor or an incompetent adult, the signing of the service plan shall be signed by the legally responsible person.

Exceptions:

a. Per G.S. 90-21.5 (see Appendix B), if the minor is receiving mental health services as allowed in this provision, the minor's signature on the service plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.

   For minors receiving outpatient substance abuse services, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (G.S. 90-21.5), the plan may be implemented without

CHAPTER VI: SERVICE NOTE/GRID

CONTENTS OF A SERVICE NOTE

Service notes shall include, but not be limited to, the following:

1. full date the service provided (month/day/year);
2. duration of service for periodic and day/night services;
3. purpose of the contact as it relates to a goal in the service plan;
4. description of the intervention/activity;
5. assessment of consumer's progress toward goals;
6. for professionals, signature and credentials, degree, or licensure of the clinician who provided the service; and
7. for paraprofessionals, signature and position of the individual who provided the service

Case management service notes (which includes CAP-MR/DD case management) shall include the following:

1. date service provided;
2. type of activity (i.e. assessing, arranging, informing, assisting, monitoring, etc.) which relates to a goal in the service plan/person-centered plan of care or activities identified on the Case Management/Service Monitoring Plan on CAP-MR/DD person-centered plan of care;
3. brief description of the activity and outcome;
4. total time (duration); and
5. signature and credentials, degree or licensure of the case manager

Note: Case management services may be documented on a case management activity log. The log shall include the consumer's name, record number and elements noted above. Initials may suffice for the signature, if each page of the case management activity log includes the signature and credentials, degree or licensure of the case manager with corresponding initials of the case manager. See Appendix D for a sample form.

FREQUENCY OF A SERVICE NOTE

PERIODIC

1. When a periodic service is provided, a service note that reflects the elements noted above shall be documented at least daily per service by the individual who provided the service.
2. If a case management activity log is used, incidents or significant events in a consumer's life which require additional activities or interventions by the case manager, a full service note shall be documented.
3. CAP-MR/DD services for which a service note, as identified above in Contents of a Service Note, is required are as follows: Crisis Services (including information as indicated in the individual's intervention plan); Individual/Caregiver Training and Education; and Specialized Consultative Services.

Note: See Grid Section for other CAP-MR/DD periodic service documentation requirements and exceptions.

Day/Night

The frequency of day/night services shall be documented as noted below. In addition to the elements noted above in Contents of A Service Note, the date(s) of attendance shall also be documented.

1. Substance Abuse Intensive Outpatient Program-daily

2. Day Treatment Programs and Partial Hospitalization-weekly
3. Psychosocial Rehabilitation-monthly ADVP, Supportive Employment, Community Rehabilitation Program (Sheltered Workshop), Day Activity-quarterly.

Note: If the duration of service is less than the above frequency, a service note shall be documented for that period of time. If Medicare is billed for partial hospitalization, Medicare documentation requirements shall be followed.

24-HOUR

The following 24-hour services shall be documented as follows:

A. Medical Programs, including Inpatient, Social Setting Detoxification for Substance Abuse- per shift;
B. Facility Based Crisis Services, Residential Treatment-Program Type(Level II), Residential Treatment-High (Level III),Residential Treatment-Secure (Level IV), PRTF- per shift;
C. Residential Treatment (Level I); Residential Treatment-Family Type (Level II)-daily;
D. Group Living, Family Living, Supervised Living-monthly or duration of stay if less than a month;
E. Residential Treatment/Rehabilitation For Individuals With Substance Abuse Disorders-per shift; and
F. Residential Recovery Programs For Individuals With Substance Abuse Disorders And Their Children-per shift

GRID

CONTENTS OF A GRID

A grid is a form that is designed to identify the goal(s) that is being addressed and with a key developed specifies the intervention/activity provided and a separate key developed which reflects the assessment of consumer's progress toward goal(s) during that episode of care. A grid shall include:

a. the full date the service was provided (month/day/year);
b. the goals that are being addressed;
c. a number or letter as specified in the key which reflects the intervention/activity;
d. a number or letter as specified in the key which reflects the assessment of the consumer's progress toward goals;
e. duration, when required; and
f. initials of the individual providing the service. The initials shall correspond to a signature on the signature log section of the grid.

The grid shall provide space where additional information may be documented as needed.

A grid, as described above, may only be used for the following services:

a. Day Supports;
b. Home and Community Supports;
c. Supported Employment Services(CAP-MR/DD);
d. *Residential Supports;
e. Residential Treatment (Level I); and
f. Residential Treatment-Family Type (Level II)

A grid shall be completed daily to reflect services provided.

*Note: Residential Supports is a blended service that includes habilitation, personal care and support; therefore, all areas shall be addressed. Elements noted in the grid address the habilitation area. Personal care and support may be addressed by using a grid, checklist or a daily note. A grid may be developed which captures all required elements (see sample) or a daily note may be used to address required areas

including but not limited to bathing, dressing, personal hygiene and other activities of daily living (see CAP-MR/DD service definitions).

EXCEPTIONS TO THE ABOVE DOCUMENTATION REQUIREMENTS

For the following services, date of service, duration of service, task performed, signature (initials if full signature included on the page) are required to be documented daily to reflect the service provided:

1. Personal Care (unless provided by a home care agency that is following their home care licensure rules);
2. Adult Day Health Care Services (for references to documentation requirements, see the Division of Aging web site at www.dhhs.state.nc.us/aging for North Carolina Adult Day Care and Day Health State Standards for Certification-10 NCAC 42Z or contact them at 919-733-3983).
3. CAP-MR/DD Respite (Non-institutional, Nursing*);*
   Note: Institutional respite shall follow the State Mental Retardation Centers documentation requirements.
4. State Funded Respite-The frequency of documentation for non CAP-MR/DD respite, is as follows:
   a. Hourly-per date of service; and
   b. Community-per duration of the event but not less than weekly
   Note: For additional respite documentation requirements, see Chapter X and Chapter XI in this manual.

Incidents or significant events in a consumer's life, which require additional activities or interventions, shall be documented.

Note: See Chapter X for documentation requirements for Tangible Supports Services [Home Modifications, Transportation, Specialized Equipment and Supplies, Personal Emergency Response System (PERS), Vehicle Adaptations, and Augmentative Communications Devices]

ADDITIONAL REQUIREMENTS

1. The completion of a service note or grid to reflect services provided shall be documented within 24 working hours. For reimbursement purposes, documentation shall be properly documented within sixty (60) calendar days from the date the service was provided to ensure the note or grid is properly documented. The area program/LME policy may be more restrictive than the allowed sixty (60) days.
2. If a service note or grid is documented after the required 24 working hours, it shall be considered a "late entry". The entry shall be noted as a "late entry" and at a minimum the date the documentation was made and the date for which the documentation should have been documented. For example, "Late entry made on 4/15/03 for 4/12/03."
3. In all cases, service notes shall be made more frequently than the above requirements when necessary to indicate significant changes in the consumer's status, needs or changes in the service plan.

CHAPTER VII: OTHER SOURCES OF DOCUMENTATION REQUIREMENTS

TREATMENT ALTERNATIVES TO STREET CRIME

(TASC)-The standard operating procedures specified in the June 30, 2000, State of North Carolina Standard Operating Procedures manual shall be followed.

SUBSTANCE ABUSE SERVICES RECORD FOR CHILD AND ADOLESCENT SELECTIVE AND INDICATED PREVENTION SERVICES

The Substance Abuse Prevention Services Record for Child and Adolescent Selective and Indicated Prevention Services record shall be required for all children and adolescents receiving substance abuse selective and indicated prevention services. The requirements of a Substance Abuse Services Record for Child and Adolescent Selective and Indicated Prevention Services are found in Appendix C. Included in the Appendix is the ASAM Adolescent Criteria for Level 0.5: Early Intervention.

CRITERION #5 SERVICES

(N.C. Medicaid Criteria for Continued Acute Stay in an Inpatient Psychiatric Facility)
Criterion #5 services shall only be provided if identified needed services within the community are not available for a minor/adolescent consumer at the discharge date and both the hospital and area program/LME are actively working on implementing the discharge plan. This service requires prior approval. Case management activities may be billed. If case management is billed, there shall be an open record on the minor/adolescent and meet the case management documentation requirements as specified in this manual.

CPT DOCUMENTATION

For CPT documentation requirements, the document "Guide To CPT Conversion for Individual and Group Outpatient Treatment Services" (7/01) shall be followed. This document can be found on the Division's web site www.dhhs.state.nc.us/mhddsas or ordered by contacting the Division's Communication and Training Section at (919) 733-7011.

1. Whenever corrections are necessary in the consumer's paper record, the following procedures shall be followed:
    a. corrections shall be made by the individual who recorded the entry;
    b. one single thin line shall be drawn through the error or inaccurate entry, making certain the original entry is still legible;
    c. record the corrected entry legibly above or near the original entry;
    d. record the date of the correction and initials of the recorder. An explanation as to the type of documentation error shall be included whenever the reason for the correction is unclear (e.g. "wrong consumer record", "transcription error");
    e. whenever omitted words cannot be inserted in the appropriate place above the record entry, the information should be made after the last entry in the record. Never "squeeze" additional information into the area where the entry should have been recorded.
2. Correcting fluid or tape shall not be used for correction of errors.

INCIDENT AND DEATH REPORTING DOCUMENTATION

Each service provider shall comply with the death reporting requirements specified in 10A 27G .0300, incident documentation requirements specified in 10A 27G .0600 and Client Rights rules as specified in Client Rights in Community Mental Health, Developmental Disabilities and Substance Abuse Services (APSM 95-2).

Administrative Requirements
An administrative system shall be developed for maintaining information on special incidents. When an incident report is completed the report shall not be referenced or filed in the service record but filed in administrative files.

FOLLOW-UP DOCUMENTATION
Follow-up documentation shall reflect attempts to ascertain why a consumer is not attending a service in accordance with the established schedule.

SIGNATURES AND COUNTERSIGNATURES
1. All entries in the service record shall be signed. For professionals, the staff member who provided the service and recorded the event shall sign their name with credentials, degree, or licensure. For paraprofessionals, the individual who provided the service and recorded the event shall sign their name and position.
2. Whenever a staff member is no longer available (extended leave, death, termination from position) to sign a record entry, a notation reflecting this shall be documented in the record with the staff member's supervisor's signature who is signing on behalf of the staff member.
3. Countersignature of entries in the service record shall be required based upon each area facility/LME's policy;
4. A rubber stamp shall be used only for medical reasons and ADA accommodations. If the individual is unable to use the stamp for medical/physical reasons, the individual shall designate an individual authorized to use the stamp. This designation shall be in writing.
5. If an electronic signature is used, the following standards shall be followed:
    - when an electronic signature is used, the provider shall be given an opportunity to review the entry for completeness and accuracy prior to electronically signing the entry;

Specialized Equipment and Supplies

1. Assessment/recommendation shall be completed by an appropriate professional that identifies the individual's need(s) with regard to the Specialized Equipment and Supplies being requested. Diagnostic information must be consistent with the recommended supplies/equipment. The assessment/recommendation must state the amount of an item the person needs. The assessment/recommendation must be updated if the amount of the item the person needs changes.
2. A copy of the physician's signature certifying medical necessity shall be included with the request for Specialized Equipment and Supplies. The physician may sign a statement on the assessment/recommendation certifying that the requested supply/equipment is medically necessary or may sign a separate document.
3. Outcomes/goals related to the person/family's utilization and/or procurement of the requested supplies/equipment must be included in the person-centered plan of care. If the equipment/supply is related to outcomes/goals already in the person-centered plan of care, this should be noted in the request for the equipment/supply. Outcomes must be consistent with the recommendations for the supplies/equipment.

Personal Emergency Response System (PERS)

Maintain a record that documents the date service is started, the dates that it is provided, and the date it is terminated.

Vehicle Adaptations

1. Recommended equipment or modification shall be justified by an assessment from a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation Specialist and accompanied by a physician's signature certifying medical necessity for the person. These assessments shall contain information regarding the rationale for selected modification, consumer pre-driving assessment-if the CAP-MR/DD consumer will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
2. Documentation regarding each of the requirements specified above, as well as a revised cost summary and person-centered plan of care signature page must be submitted to the Lead Agency Local Approver in order to obtain prior approval of the requested Vehicle Adaptations.

Augmentative Communications Devices

1. Assessment/ recommendation signed and dated by a NC Licensed Speech-Language Pathologist with the SLP's license number shall be submitted with the request. The assessment/ recommendation is also signed and dated by other appropriate professionals as needed. The recommendation must be less than one year old from the date the request is received in the Lead Agency Local Approval Office. The assessment confirms medical need for the equipment rather than educational need and identifies the person's need(s) with regard to Augmentative Communication equipment being requested. A copy of the physician's statement certifying medical necessity shall be included with the request.
2. The request shall include clear documentation that the equipment is necessary to enable the individual to produce and engage in communication, either spoken, written, or both, in the absence of functional oral language. Information shall be provided that includes the person's hearing status, visual status, physical status, access for the device requested (i.e. use of hand, visual scanning, auditory scanning, etc.), cognitive status, and primary communication method(s).
3. Outcomes for teaching the use of the device to the consumer and his/her care providers that match the assessment results/device(s) requested shall be included.

4. The estimated life of the equipment, as well as the length of time the person is expected to benefit from the equipment, shall be indicated in the request.
5. An invoice from the supplier that shows the date the Augmentative Communication was provided to the person, and the cost including related charges (for example, applicable delivery charges) shall be maintained by the Lead Agency.

Inclusive Day Programs

1. For each consumer, the inclusive day program record shall include a service plan, if applicable, strategies or activities which are the responsibility of the inclusive program provider, and an attendance hour record.
2. Staff who support children in these placements shall document a service plan as noted in the Individualized Service Plan Section and service notes as described in the Service Notes/Grid Section.

Developmental Day Services-Typically Developing Children

Documentation as required by the NC Division of Child Development's Child Care Requirements, Subchapter 3U-Child Day Care Rules shall be followed. The Division of Child Development may be contacted by calling (919)662-4499.

Developmental Day Services-Before/After School

The record shall contain a copy of the IEP or IFSP from the regular day program.

Community Rehabilitation Program (Sheltered Workshop Programs)

The documentation requirements specified in this document do not apply to consumers supported by the Division of Vocational Rehabilitation. For these consumers, documentation requirements specified by the Division of Vocational Rehabilitation shall be followed.

CHAPTER XII: SERVICES NOT REQUIRING A SERVICE PLAN

PENDING RECORDS

1. Screenings;
2. Referrals;
3. Drop-In Center Services;
4. Case Consultation; and
5. Assertive Outreach

SCHOOL RECORDS DOCUMENTATION REQUIREMENTS (ADETS AND DES)

Documentation for school records shall include:

1. Information regarding the initial assessment to determine eligibility to attend school;
2. The appropriateness of the referral to a treatment resource, if applicable;
3. For ADETS, a copy of Form No. DMH-508, "DWI Services Certificate of Completion";
4. For DES, a copy of Form No. DMH-4401, "Drug Education School of Completion Form";
5. Documentation of other relevant transactions and student contacts, i.e. referral to another county and/or non-compliance issues and outcomes;
6. Pre-test and post-test scores; and
7. Homework assignments, if any.

A record shall be maintained in the administrative files for each student.

An individual may voluntarily move from student status to consumer status when it has been determined that the individual is in need of active treatment/habilitation and is accepted as a consumer. Once a student becomes a consumer, a consumer record shall be opened.

A determination shall be made whether ADETS or DES record shall be incorporated into the consumer record.

HELP-LINE, CONSULTATION, EDUCATION AND PRIMARY PREVENTION, EMPLOYEE ASSISTANCE PROGRAM (EAP) DOCUMENTATION REQUIREMENTS

Documentation for other service records shall include:

1. Help-Line
    a. Caller's name, address and telephone number, when possible;
    b. Probable age and disability of the individual who is the subject of the call;
    c. Brief description of the type of complaint or problem;
    d. Disposition/recommendation for further care;
    e. Date and time of contact; and
    f. Authentication by persons receiving the call.
2. Consultation, Education and Primary Prevention
    a. Person/agency receiving consultation;
    b. Type of group participating in educational or prevention program;
    c. Approximate number of participants;
    d. Date and duration (time) of the event;
    e. Description of the event; and
    f. Staff member participating in the event.